



Vitreous Retina Macula Consultants of New York, P.C.

Patient Registration Form

NP v.2018

Patient Information

Last Name: _____ First Name: _____ M.I.: _____
Address: _____ Apt #: _____
City: _____ State: _____ Zip: _____
Home #: _____ Cell #: _____ Work #: _____
Date of Birth: _____ Last 4 SS#: _____ Marital Status: S M D W Gender: M F
Occupation: _____ Email: _____
Race: _____ Ethnicity: _____ Language: _____
How were you referred to our office?: Referring MD PCP Online Patient/Other: _____

Medical Information

Emergency Contact: _____ **Pharmacy Contact:** _____
Phone: _____ Address: _____
Relationship: _____ Phone: _____
Referring MD: _____ **Primary (PCP) MD:** _____
Phone: _____ Phone: _____
Address: _____ Address: _____
City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

Insurance Information

Are you currently employed? **YES** **NO**
Do you/your spouse have employee health insurance with an employer who employs 20 or more? Y / N
Primary Insurance: _____ **Secondary Insurance:** _____
Policy Number: _____ Policy Number: _____
Group #: _____ Group #: _____
Policy Holder Name: _____ Policy Holder Name: _____
Policy Holder DOB: _____/_____/_____ Policy Holder DOB: _____/_____/_____
Relationship to Policy Holder: _____ Relationship to Policy Holder: _____

Authorization and Release

I hereby authorize my physician to furnish information to insurance carriers concerning my illness, accident and/or treatment. I hereby assign the physician all payments for medical service rendered to myself or to my dependents. I understand I am financially responsible for any charge incurred whether or not paid for by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Patient, Parent or Legal Guardian

Date



Account Number: _____

Consent to Treat

I hereby authorize employees and agents of Vitreous Retina Consultants of New York, P.C. d/b/a VRMNY including physicians, technicians, and other employees and staff members to render medical evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency.

Patient Name

Date

Signature of Patient, Parent, or Legal Guardian

Complete this section ONLY if patient is a minor or requires a Legal Guardian

I consent for _____ to authorize evaluation and treatment for the patient identified above when I am not available. I understand that this authorizes the foregoing person(s) to consent to medical and surgical procedures and immunizations for the patient. The duration of this consent is indefinite and continues until revoked in writing.

Signature of Patient, Parent, or Legal Guardian

Date



Account Number: _____

Financial Responsibility

I hereby authorize Vitreous Retina Consultants of New York, P.C. d/b/a VRMNY to apply for benefits on my behalf and for payment of medical benefits directly to Vitreous Retina Consultants of New York, P.C. d/b/a VRMNY for services rendered. I request payments of Medicare, Medigap and/or any other insurance company to be made directly to Vitreous Retina Consultants of New York, P.C. d/b/a VRMNY. Authorization is hereby granted to release information contained in the patients' medical record or the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical claim. I understand that I am financially responsible for all charges for services rendered which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to Vitreous Retina Consultants of New York, P.C. d/b/a VRMNY. I also understand that a returned check fee of \$35 will be assessed if the check is returned by my bank.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before services are rendered.

Patient Name

Date

Signature of Patient, Parent, or Legal Guardian

Credit Card on File Consent Form

I, _____, hereby authorize Vitreous Retina Consultants of New York, P.C. d/b/a VRMNY to store and charge my credit card, ending in x_____. I understand that my information will be saved on file for future transactions.

Patient Name

Date

Signature of Patient, Parent, or Legal Guardian



Account Number: _____

Notice of Privacy Practices and Acknowledgement of Receipt

Patient Name: _____

Date: ____/____/____

The Notice of Privacy Practices describes how Protected Health Information about you may be used and disclosed and how you can get access to this information. Please review carefully. Vitreous Retina Consultants of New York, P.C. d/b/a VRMNY is required by law to protect the privacy of health information that may reveal your identity, and to provide you with a copy of this notice, which describes the health information privacy practices of our practice, its medical staff, and affiliated health care providers that jointly perform payment activities and business operations with our Practice. "Protected Health Information" is information about you, including demographic information, that may identify you as well as genetic information, and information that relates to your past, present or future physical or mental health or condition and related health care services.

On ____/____/____ I, _____, received a copy of this office's Notice of Privacy Practices.

Patient Name

Date

Signature of Patient, Parent, or Legal Guardian

Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Employee Initials: _____

This Acknowledgement Form will become part of your permanent medical record.



Account Number: _____

Clinical Summary Request

I hereby request to receive a Clinical Summary of my visit. I understand that this will be provided to me after my appointment is complete, either at the time of departure or via the portal. I further acknowledge that by signing this I am entitled to receive a Clinical Summary following each visit hereafter:

Patient Name

Date

Signature of Patient, Parent, or Legal Guardian

Patient Preferences Regarding Communication of PHI (Protected Health Information)

Keeping our patient's information private is important to us, and by default we will disclose information related to the patient's Billing Account and Medical Conditions only to the patient or legal guardian.

If you would like to add additional contacts, other than the patient or legal guardian, that VRMNY is allowed to disclose this type of information to, please complete the fields below and select the appropriate checkboxes based on your approval for each person you listed. If the End Date is left blank, then the duration of this authorization is indefinite unless otherwise revoked in writing.

Contact Name

Relationship to Patient

Contact Phone Number

End Date

Billing Account Information

Medical Condition Information

Additional Notes: _____



Account Number: _____

**BENEFICIARY AUTHORIZATION
FOR MEDICARE PART B PATIENTS ONLY
“PATIENT REQUEST FOR PAYMENT ON FILE”**

MEDICARE #: _____

I request that payment of authorized benefits be made either to me or on my behalf to Vitreous Retina Consultants of New York, P.C. d/b/a for any services furnished by Vitreous Retina Consultants of New York, P.C. d/b/a. I authorize any holder of medical information about me released to the payer and its agents any information needed to determine these benefits payable to related services.

I understand my signature request that payment be made and authorized release of medical information necessary to pay the claim. If other health insurance coverage is indicated, my signature authorizes release of the information to the insurer or agency shown. In assigned cases, the physician or Vitreous Retina Consultants of New York, P.C. d/b/a agrees to accept the charge, and the patient is responsible only for the deductible, coinsurance and non-covered services. Coinsurance and deductible are based upon the charge determination of the payer.

Please sign and print your name exactly as it appears on your Medicare card.

Patient Name

Date

Signature of Patient, Parent, or Legal Guardian



Account Number: _____

Image Consent Form

I, _____, hereby give my consent to Vitreous Retina Macula Consultants of New York, P.C. d/b/a VRMNY permission to use my Ophthalmic Images for the purpose of its publications, advertising or other (social) media activities.

I understand my identity or any of my protected health information (PHI) will NOT be exposed.

Images shared will include, but may not be limited to any Optical Coherence Tomography (OCT), Optos, Fundus Photos, Heidelberg Retina Angiograph (HRA) and Angiograms.

This consent may be revoked at any time with written request by the patient.

By signing below, I confirm that I understand this consent form.

Patient Name

Date

Signature of Patient, Parent, or Legal Guardian

Consent to Leave a Detailed Message

I, _____, hereby give my consent to Vitreous Retina Macula Consultants of New York, P.C. d/b/a VRMNY permission to leave a detailed message on either answering service to the number(s) on file.

This information may include, but not limited to, appointment details, billing information, medication information.

This consent may be revoked at any time with written request by the patient.

By signing below, I confirm that I understand this consent form.

Patient Name

Date

Signature of Patient, Parent, or Legal Guardian